STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 01 B. WING	07/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD HEALTHCARE CENTER	2400 COLLEGE AVE GOSHEN, IN 46526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Dates: 07/21/14 and 07/22/14 Facility Number: 000091 Provider Number: 155689 AIM Number: 100290080 Surveyor: Dennis Austill, Life Safety Code Specialist At this Life Safety Code survey, Courtyard Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original section of the building consisting of the A Wing, B Wing, the C wing and the main dining room was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and was fully sprinklered with the exception of a storage shed on the roof. The facility has	K010000	Please accept this Plan of Correction as our facility's Credible Allegation of Compliance for our Life Safety Code Recertification and State Licensure Survey conductedon 7/21/2014 and 7/22/2014. Submission of this Plan of Correction is not an admission by Courtyard Healthcare Centerthat the deficiencies alleged in the survey are accurate or that they depict the level of safety and security provided to the residents of our facility. This Plan of Correction is being submitted solely because doing so is required by State and Federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	a fire alarm system with smoke detection in the corridors and in areas open to the corridors. The resident rooms are provided with single station, hard wired smoke detectors. The facility has a capacity of 188 and had a census of 156 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a storage shed on the roof that was not sprinklered and two detached, garage sized storage sheds used for storage by the facility that were not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/28/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or			

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	capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 3 of 3 sets of double corridor doors closed and latched automatically into the door frame. This deficient practice could affect at least 15 residents using the Main Activity room, Birch lounge or the Cedars lounge as well as staff and visitors. Findings includes: Based on observations with the Maintenance Director on 07/21/14 from 3:00 p.m. to 4:45 p.m., and with the Director of Nursing on 07/22/14 at 10:10 a.m., the Main Activity room, Birch Lounge and the Cedars Lounge were provided with a set of double corridor doors equipped with a slide bolt latch on one door which had to be manually latched to allow the other door to latch into the first door. The Maintenance Director at the time of observation of the Activity room and Birch lounge and at the exit conference on 7/22/14 at 1:30	K010018	**K018** Facility will equip the three corridor doors noted in the 2567 with automatic slide bolts that meet the NFPA requirements. **Corrective Actions:** The corridor doors noted in the 2567, namely those leading to the Activity Room, the Cedar Wing Lounge, and the Birch Wing Lounge—will be modified so as to meet the NFPA requirements. **How Others Identified:** These are the only three sets of corridor doors of this type in the facility. As noted in the 2567, residents in those rooms may be affected by this alleged deficient practice. **Preventative Measures:** Once equipped with the automatic slide bolts, these three doors will be placed on a Preventive Maintenance Schedule, along with the repaired laundry door noted under “K029”, where they will be checked to assure that they latch appropriately. These checks will occur weekly for the next six months, at which time their	08/21/2014

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	p.m. acknowledged the doors would require manual latching. 3.1-19(b)		frequency may be reduced at the direction of the facility's QAPI Committee. **Monitoring:** The results of the PM checks noted under "Preventive Measures" (above) will be submitted to the facility's QAPI Committee for review on a monthly basis for the next six months. **Date of Completion: August 21, 2014 IDR requested as the facility believes that these three rooms are not covered by this regulation.**	
K010025 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 3 smoke barriers on Cedars wing was protected to maintain the fire resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier	K010025	**K025** Facility will continue to ensure that smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. **Corrective Actions:** The smoke barrier penetration noted during the survey has been repaired. **How Others Identified:** As noted in the 2567, this alleged deficient practice could affect 10	08/21/2014

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	shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect at least 10 residents on the Cedars wing as well as staff and visitors if smoke from a fire were to infiltrate the protective barriers. Findings include: Based on observation with the Administrator and Maintenance Director on 07/22/14 at 10:50 a.m., there was an exposed penetration through the Cedar Wing, Center hall, smoke barrier above the ceiling tile where a one inch penetration by cable through the drywall was not firestopped. Based on interview at the time of observation, the Administrator and Maintenance Director acknowledged the unprotected opening through the smoke barrier. 3.1-19(b)		residents on Cedar Wing. **Preventative Measures:** Smoke barriers have been placed on a schedule whereby they will be visually checked for compliance with K025, monthly, as a part of the facility's Preventive Maintenance schedule. Documentation of these observations will be forwarded to the facility's QAPI Committee for review. **Monitoring:** The results of the visual checks completed under "Preventive Measures" (above) will be reviewed by the facility's QAPI Committee at each meeting it holds in the next six months. **Date of Completion: August 21, 2014**	
K010029 SS=A	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4			

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	protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 5 doors serving hazardous areas such as a laundry closed and latched to prevent the passage of smoke. This deficient practice occurred in a service hall and would not directly affect residents but would affect staff. Findings include: Based on observation with the Maintenance Director on 07/21/14 at 3:05 p.m., the door to the clean laundry room self closed but did not latch into the frame. Based on interview at the time of observation, the Maintenance Director acknowledged the clean laundry room door did not latch to prevent the passage of smoke. 3.1-19(b)	K010029	**K029** Facility will continue to ensure that doors serving hazardous areas, such as laundry, close and latch to prevent the passage of smoke. **Corrective Actions:** The laundry door has been repaired so that it closes and latches to prevent the passage of smoke, in accordance with K029. **How Others Identified:** As noted in the 2567, the door found out of compliance is in a service hallway and would not affect residents. **Preventative Measures:** This door, along with the three noted under "K018", will be placed on a Preventive Maintenance Schedule, where it will be checked to assure that it latches appropriately. These checks will occur weekly for the next six months, at which time their frequency may be reduced at the direction of the facility's QAPI Committee. **Monitoring:** The results of the PM checks noted under "Preventive Measures" (above) will be submitted to the facility's QAPI Committee for review on a monthly basis for the next six months. **Date of Completion:**	08/21/2014

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			August 21, 2014	
K010038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure not more than one delayed egress lock device complying with NFPA 101, 7.2.1.6.1 was provided in any egress path as permitted by NFPA 101, 19.2.2.2.4, Exception No. 2 in 1 of 13 egress paths. This deficient practice could affect at least 10 residents as well as staff and visitors. Findings include: Based on observation with the Director of Nursing on 07/22/14 at 10:40 a.m., the Cedars Annex corridor entrance and Cedars Annex corridor exterior exit doors were each provided with delayed egress locks with signage. At the exit conference on 07/22/14 at 1:30 p.m., the Administrator and the Maintenance Director acknowledged the two doors were provided with a 15 second delayed egress magnetic lock and were within the same egress path. 3.1-19(b)	K010038	**K038** Facility will continue to have its exits arranged so as to be readily accessible at all times. **Corrective Actions:** The Cedar Wing Annex doors have been rearranged so as to provide only one delayed egress. To do so, the delayed egress on the 1st set of doors has been removed. **How Others Identified:** As noted in the 2567, this alleged deficient practice could affect at least 10 residents. **Preventative Measures:** Maintenance Supervisor has been trained on the delayed egress requirements noted in "K038". **Monitoring:** All Code Alert (i.e. Wanderguarded) doors are checked for proper functioning on a weekly basis. As the door in question is now equipped with Code Alert, it will be checked for proper functioning weekly along with the rest of the Code Alert doors. These door checks will be submitted to and reviewed by the facility's QAPI Committee for the next six months. **Date of Completion: August21, 2014 IDR requested as facility does not believe that this area, as it is used, is in violation of K038.**	08/21/2014
K010048	NFPA 101			

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SS=C	LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review, observation and interview; the facility failed to develop a written fire safety plan to address staff response to the activation of hard wired, single station smoke detectors installed in 113 of 113 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the Nursing Home Smoke Detector Status Report (State Form 55004[R/3-13]) completed by the Maintenance Director on 07/21/14, the form indicated the hard wired smoke detectors provided in each resident room provided a visual and audible signal at	K010048	**K048** Facility will continue to have a written plan for the protection of all patients and for their evacuation in the event of an emergency. **Corrective Actions:** Facility's Fire Safety Plan has been amended to include instructions as to what staff is to do in the case of a hardwired smoke detector being activated. **How Others Identified:** This alleged deficient practice has the potential to affect all of the facility's residents. **Preventative Measures:** Staff will be trained on how to react when a smoke detector audibilizes. Facility will begin incorporating smoke detector audibilization into its Fire Drill schedule, with three such drills being held, one on each shift, over the next three months, to ensure that staff react appropriately to the audible smoke detector signals. Fire Drill Report will be amended to indicate whether the drill in question was one that was initiated by the "fire indicator" or a "smoke detector signal". **Monitoring:** Fire Drill Reports will be submitted to, and reviewed by, facility's QAPI Committee for the next six months. **Date of Completion: August 21, 2014**	08/21/2014

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	the nurses' stations that attend each room. Based on observation on 7/22/14 with the Maintenance Director and Administrator at 11:00 a.m., the hard wired smoke detector in room 216 was tested with canned smoke and when activated, did not send a signal to the nurses' station. At that time, the Maintenance Director amended the form. Based on interview at the time of observation, when asked if the staff's response to the hard wired smoke detectors in the resident rooms was addressed in the facility's fire and disaster plan, the Administrator acknowledged he did not know. At the exit conference on 07/22/14 at 1:30 p.m., the Administrator did not provide a written fire safety plan to address staff response to the activation of hard wired, single station smoke detectors installed in 113 of 113 resident sleeping rooms. 3.1-19(a)			
K010050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are			

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	conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 1. Based on record review and interview, the facility failed to ensure 7 of 7 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on review of Fire Drill Reports on 07/21/14 at 11:30 a.m. with the Maintenance Director, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m. for the past twelve months lacked verification of the transmission of the signal for drills conducted on 05/30/14 at 11:00 a.m., 03/12/14 at 7:45 p.m., 02/28/14 at 8:00 a.m., 12/30/13 at 4:00 p.m., 11/26/13 at 10:00 a.m., 09/30/13 at 2:00 p.m. and 08/28/13 at 1:00 p.m. Based on interview at the exit conference on 07/22/14 at 1:30 p.m., the Administrator	K010050	**K050** Facility will continue to conduct Fire Drills at unexpected times under varying conditions, at least quarterly on each shift. **Corrective Actions:** Fire Drill form will be amended to include documentation that a signal was sent to and received by the monitoring company. **How Others Identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Fire Drill Report will be amended to indicate whether the drill in question was one that was initiated by the "fire indicator" or a "smoke detector signal". M**onitoring:** Fire Drill Reports will be submitted to, and reviewed by, facility's QAPI Committee for the next six months. **Date of Completion: August 21, 2014 IDR requested as facility believes its Fire Drills and Fire Drill Schedule meet the requirements of K050.** Facility also disputes the 2567's language that the "Administrator questioned the requirement of ensuring fire drills are held at unexpected times under varying conditions". What was questioned was how our Fire Drill schedule did not meet the requirement that drills are held "at unexpected times".	08/21/2014

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	questioned the requirement of documenting the transmission of the fire alarm signal to the monitoring station for the aforementioned fire drills. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure 12 of 12 fire drills were conducted under varied conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on review of Fire Drill Reports on 07/21/14 at 11:30 a.m. with the Maintenance Director, 10 of 12 fire drills conducted over the past four quarters were conducted near the end of the month: on 1/30/14, 2/28/14, 4/30/14, 5/30/14, 6/27/14, 12/30/13, 10/29/13, 9/30/13 and on 8/28/13. Based on interview at the exit conference on 07/22/14 at 1:30 p.m., the Administrator questioned the requirement of ensuring fire drills are held at unexpected times under varying conditions. 3.1-19(b) 3.1-51(c)			

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K010056 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 5-1.1 states sprinklers shall be installed throughout the premises. LSC Section 9.7.3.1 allows alternative automatic extinguishing systems other than an automatic sprinkler system such as a water mist, carbon dioxide, dry chemical foam or a standard extinguishing system of another type in lieu of an automatic sprinkler system.	K010056	**K056** Facility will continue to ensure that a complete automatic sprinkler system is installed in accordance with NFPA 13, Section 5-1.1. **Corrective Actions:** The eight-by-twelve foot shed noted in the 2567 has been equipped with an automatic sprinkler system. **How Others Identified:** This alleged deficient practice has the potential to affect all residents in the older part of the building. **Preventative Measures:** The shed sprinkler system will be tested regularly by the facility's contracted fire system inspection company, along with the rest of facility's sprinkler system. M**onitoring:** Copies of sprinkler	08/21/2014

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	Such systems shall be installed, inspected and maintained in accordance with NFPA standards and shall activate the building fire alarm system. This deficient practice could affect residents, staff and/or visitors in the original section of the building. Findings include: Based on observation with the Maintenance Director on 07/21/14 from 10:15 a.m. to 11:15 a.m., a eight foot by twelve foot shed located on the roof of the original section of the building lacked sprinkler protection, or protection by an alternative extinguishing system. The shed was constructed of a wood frame and floor with an aluminum exterior and was used primarily for the storage of air handler filters. Based on interview at the time of observation, the Maintenance Director acknowledged the lack of extinguishing protection in the shed located on the roof. 3.1-19(b)		system inspections and checks will be forwarded to the facility's QAPI Committee for review at each meeting for the next 12 months. **Date of Completion: August 21, 2014 IDR requested as facility does not believe that shed requires the sprinkler protection delineated in K056.**	
K010062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested			

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	155689	A. BUILDING 01 B. WING	07/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD HEALTHCARE CENTER	2400 COLLEGE AVE GOSHEN, IN 46526

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	periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Maintenance Director from 3:00 p.m. to 4:45 p.m. on 07/21/14, and with the Director of Nursing from 9:30 a.m. to 10:45 a.m. on 07/22/14, paint was noted on the sprinkler heads in the closets of resident rooms 101, 117, 136, 229 and 212. Paint was noted on the sprinkler heads near the window in resident rooms 200, 218 and 228. Based on interview at the exit conference on 07/22/14 at 1:30 p.m., the Maintenance Director acknowledged the aforementioned	K010062	**K062** Facility will continue to ensure that required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. **Corrective Actions:** The sprinkler heads noted as having paint on them—those in the closets in rooms #101, 117, 136, 212, and 229 near the windows in resident rooms #200, 218, and 228—have been replaced. **How Others Identified:** All sprinkler heads in the building have been assessed head-by-head and each that was found to have paint on them have been replaced. **Preventative Measures:** Sprinkler heads will be placed on a Preventive Maintenance schedule whereby they will be checked for paint and corrosion every three months for the next year, with the results of this PM check being forwarded to the facility's QAPI Committee for follow-up and review. **Monitoring:** QAPI Committee will review the sprinkler head audits for the next year. **Date of Completion: August 21, 2014**	08/21/2014

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	sprinklers had paint on them. 3.1-19(b)			
K010064 SS=A	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 28 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. This deficient practice would have a minimal affect on residents, staff and/or visitors. Findings include: Based on observation with the Maintenance Director at 3:10 p.m. on 07/21/14, the annual maintenance tag attached to the portable fire extinguisher located in the clean laundry room indicated the last annual maintenance	K010064	**K064** Facility will continue to provide portable fire extinguishers in accordance with 9.7.4.1. 19.3.5.6, NFPA 101. **Corrective Actions:** The fire extinguisher noted in the 2567 was replaced during the survey. **How Others Identified:** As noted in the 2567, this alleged deficient practice would have a minimal affect on residents. **Preventative Measures:** Fire extinguishers are checked monthly through the facility's Preventive Maintenance Program. The extinguisher noted in the 2567—in laundry—has been added to the list of extinguishers to be checked monthly. **Monitoring:** The Preventive Maintenance documentation on fire extinguishers will be forwarded to the facility's QAPI Committee, monthly for the next 12 months, for review and follow-up. **Date of Completion: August 21, 2014**	08/21/2014

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	procedure for the extinguisher was performed in 2011. Based on interview at the time of observation, the Maintenance Director acknowledged the annual maintenance procedure for the aforementioned portable fire extinguisher had not been completed. 3.1-19(b)			
K010075 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 1 of 113 resident rooms. This deficient practice could affect at least 10 residents as well as staff and visitors on the Cedars wing center hall. Findings include:	K010075	**K075** Facility will modify the containers it uses for Infection Control so as to adhere to K075. **Corrective Actions:** Facility will modify the containers it uses for Infection Control so as to adhere to K075. **How Others Identified:** As noted in the 2567, this alleged deficient practice has the potential to affect upwards of 10 residents in the facility, namely those residing in rooms where Isolation Precautions are in effect. **Preventative Measures:** Staff has been educated on the	08/21/2014

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	Based on observation with the Director of Nursing on 07/22/14 at 10:45 a.m., one 32 gallon container of biohazardous soiled linen and one 32 gallon container of biohazardous trash were adjacent to one another in resident room 220. Based on an interview at the time of observation, the Director of Nursing confirmed the containers were used for biohazardous waste and linen. 3.1-19(b)		facility's new procedures for the collection and storage of soiled and hazardous materials. Infection Control Rounds will be conducted on residents for whom Isolation Precautions are in effect to ensure that the facility remains in compliance with K075. Such rounds will be completed weekly for the 1st four weeks, then monthly for the next 5 months, then quarterly for the next six months. **Monitoring:** Results of the Infection Control Rounds noted under "Preventive Measures" (above) will be forwarded to the facility's QAPI Committee for review and follow-up. **Date of Completion: August 21, 2014 IDR requested as facility does not believe that its isolation procedures, as they were during the survey, were out of compliance with this regulation.**	
K010130 SS=C	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for hard wired smoke detectors installed in 113 of 113 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient	K010130	**K130** Facility will continue to adhere to the NFPA requirements, as written. **Corrective Actions:** Facility has implemented a Preventive Maintenance program for hard wired smoke detectors based on the Manufacturer's Recommendations, namely that they be sprayed with canned air once per year. Smoke detectors will be blown with canned air	08/21/2014

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	practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of the Nursing Home Smoke Detector Status Report (State Form 55004[R/3-13]) completed by the Maintenance Director on 07/21/14 and amended on 07/22/14, the form indicated hard wired smoke detectors were provided in each resident room. Based on observation during tours of the facility on 7/21/14 and 07/22/14 with the Maintenance Director, Director of Nursing and Administrator, the hard wired smoke detectors in each resident room was confirmed. Based on interview on 07/22/14 at 11:00 a.m., when asked if the facility had a preventive maintenance program for the hard wired smoke detectors in the resident rooms, the Maintenance Director indicated he thought the company that inspected the fire alarm system checked them. At the exit conference on 07/22/14 at 1:30 p.m., no documentation was provided to demonstrate the hard wired smoke detectors in the resident rooms were maintained. 3.1-19(a)		before August 21, 2014. **How Others Identified:** As noted in the 2567, all residents have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Facility will implement a Preventive Maintenance program for hard wired smoke detectors. **Monitoring:** Preventive Maintenance documentationon hard wired smoke detectors will be reviewed at the facility's September 2014 and September 2015 QAPI meetings. **Date of Completion: August 21, 2014 IDR requested as facility does not believe it was out of compliance with its smoke detector maintenance requirements at the time of the survey.**	

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K010143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 2 of 3 liquid oxygen storage areas where oxygen transferring takes place were provided with continuous mechanical ventilation. This deficient practice could affect 20 of 156 residents. Finding include: Based on observation on 07/21/14 at 3:30 p.m. with the Maintenance Director and on 07/22/14 at 10:40 a.m. with the Director of Nursing, the Birch Wing and Cedars Wing oxygen storage/transfer rooms were provided with a mechanically operated vent fan, but they were not working. Both fans were checked with a	K010143	**K143** The facility will continue to adhere to the requirements of K143 as they relate to the transferring of oxygen. **Corrective Actions:** The continuous mechanical ventilation systems are operational in both oxygen storage areas noted in the 2567. **How Others Identified:** As noted in the 2567, this alleged deficient practice has the potential to affect 20 of the facility's 156 residents. **Preventative Measures:** All oxygen storage areas will be placed on a Preventive Maintenance schedule to ensure that the continuous mechanical ventilation systems work as designed. The schedule to check these systems will be weekly for the 1st three months and monthly	08/21/2014

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	strip of tissue. Based on interview at the times of observation, the Maintenance Director and the Director of Nursing acknowledged the fans were not running continuously. 3.1-19(b)		thereafter. **Monitoring:** The Preventive Maintenance documentationon on the continuous mechanical ventilation systems will be forwarded to the facility's QAPI Committee for review and follow-up, whenever a PM check on the systems has been completed, for the next 12 months. **Date of Completion: August 21, 2014**	
K010144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to exercise 2 of 2 generators for 12 of 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:	K010144	**K144** Facility will continue to inspect its generators weekly and exercise them under load for 30 minutes per month. **Corrective Actions:** Preventive Maintenance documentation on the generators has been revised so that there are two sets—one for each generator—instead of one set. Amperage has been added to the Generator PM checks. Load testing was completed and has been scheduled to be completed annually. Generators were tested and found to have transfer times of 9.5 and 9.7 seconds A second "letter of reliability" has been requested by the facility's natural gas supplier. **How Others Identified:** As noted in the 2567, this alleged deficient practice has the potential to affect all of the facility's residents. **Preventative**	08/21/2014

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	a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the emergency generator monthly test log maintained through electronic media with the Maintenance Director on 07/21/14 from 11:15 a.m. to 12:30 p.m., it could not be determined if the two generators met the requirements of Chapter 6-4.2 of NFPA 110 in that the only information documented was the start/end time, beginning engine oil pressure, ending engine oil pressure, ending water temperature and the battery voltage for each generator. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned issues regarding the generator. 3.1-19(b)		**Measures:** The Preventive Maintenance documentation, with respect to the generator, has been amended to include amperage and load. Annual load testing has been arranged for in subsequent years. Load testing will include documentation of transfer times **Monitoring:** Generator Preventive Maintenance documentation will be forwarded to the facility's QAPI Committee for review for each of the next six months and annual thereafter. **Date of Completion: August 21, 2014**	

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	2. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 12 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the emergency generator monthly test log maintained through electronic media with the Maintenance Director on 07/21/14 from 11:15 a.m. to 12:30 p.m., documentation of generator load transfer time for the past twelve months was not available for review. Based on interview at the time of record review, the Maintenance Director indicated no additional generator transfer time documentation for generator load transfer time was available for review			

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	and acknowledged generator load transfer time was not documented. 3.1-19(b) 3. Based on interview, the facility failed to ensure the off-site fuel source for 2 of 2 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all residents, staff and			

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	visitors. Findings include: Based on interview with the Maintenance Director at 11:15 a.m. on 07/21/14, the fuel source for the two emergency generators is natural gas. Additionally, based on interview with the Maintenance Director, the facility did not have a letter from their natural gas provider indicating the natural gas was from a reliable source. 3.1-19(b)			
K020000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Dates: 07/21/14 and 07/22/14 Facility Number: 000091 Provider Number: 155689 AIM Number: 100290080 Surveyor: Dennis Austill, Life Safety Code Specialist	K020000	Please accept this Plan of Correction as our facility's Credible Allegation of Compliance for our Life Safety Code Recertification and State Licensure Survey conductedon 7/21/2014 and 7/22/2014. Submission of this Plan of Correction is not an admission by Courtyard Healthcare Centerthat the deficiencies alleged in the survey are accurate or that they depict the level of safety and security provided to the residents of our facility. This Plan of Correction is being submitted solely because doing so is	

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	At this Life Safety Code survey, Courtyard Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The new 2011 addition of the building consisting of the D Wing was surveyed with Chapter 18, New Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. The resident rooms are provided with single station, hard wired smoke detectors. The facility has a capacity of 188 and had a census of 156 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a storage shed on the roof that was not sprinklered and two detached, garage sized storage sheds used for storage by the facility that were not sprinklered. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the		required by State and Federal law.	

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	following:			
K020048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review, observation and interview; the facility failed to develop a written fire safety plan to address staff response to the activation of hard wired, single station smoke detectors installed in 113 of 113 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the Nursing Home Smoke Detector Status Report (State	K020048	**K048** Facility will continue to have a written plan for the protection of all patients and for their evacuation in the event of an emergency. **Corrective Actions:** Facility's Fire Safety Plan has been amended to include instructions as to what staff is to do in the case of a hardwired smoke detector being activated. **How Others Identified:** This alleged deficient practice has the potential to affect all of the facility's residents. **Preventative Measures:** Staff will be trained on how to react when a smoke detector audibilizes. Facility will begin incorporating smoke detector audibilization into its Fire Drill schedule, with three such drills being held, one on each shift, over the next three months, to ensure that staff react appropriately to the audible smoke detector signals. Fire Drill Report will be amended to indicate whether the drill in question was one that was initiated by the "fire indicator" or a "smoke detector signal". **Monitoring:** Fire Drill Reports will be submitted to, and	08/21/2014

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	155689	A. BUILDING 02 B. WING	07/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD HEALTHCARE CENTER	2400 COLLEGE AVE GOSHEN, IN 46526

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	Form 55004[R/3-13]) completed by the Maintenance Director on 07/21/14, the form indicated the hard wired smoke detectors provided in each resident room provided a visual and audible signal at the nurses' stations that attend each room. Based on observation on 7/22/14 with the Maintenance Director and Administrator at 11:00 a.m., the hard wired smoke detector in room 216 was tested with canned smoke and when activated, did not send a signal to the nurses' station. At that time, the Maintenance Director amended the form. Based on interview at the time of observation, when asked if the staff's response to the hard wired smoke detectors in the resident rooms was addressed in the facility's fire and disaster plan, the Administrator acknowledged he did not know. At the exit conference on 07/22/14 at 1:30 p.m., the Administrator did not provide a written fire safety plan to address staff response to the activation of hard wired, single station smoke detectors installed in 113 of 113 resident sleeping rooms. 3.1-19(a)		reviewed by, facility's QAPI Committee for the next six months. **Date of Completion: August 21, 2014**	
K020050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly			

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	on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 1. Based on record review and interview, the facility failed to ensure 7 of 7 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on review of Fire Drill Reports on 07/21/14 at 11:30 a.m. with the Maintenance Director, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m. for the past twelve months lacked verification of the transmission of the signal for drills conducted on 05/30/14 at 11:00 a.m., 03/12/14 at 7:45 p.m., 02/28/14 at 8:00 a.m., 12/30/13 at 4:00 p.m., 11/26/13 at	K020050	**K050** Facility will continue to conduct Fire Drills at unexpected times under varying conditions, at least quarterly on each shift. **Corrective Actions:** Fire Drill form will be amended to include documentation that a signal was sent to and received by the monitoring company. **How Others Identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures:** Fire Drill Report will be amended to indicate whether the drill in question was one that was initiated by the “fire indicator” or a “smoke detector signal”. M**onitoring:** Fire Drill Reports will be submitted to, and reviewed by, facility’s QAPI Committee for the next six months. **Date of Completion: August 21, 2014 IDR requested as facility believes its Fire Drills and Fire Drill Schedule meet the requirements of K050.** Facility also disputes the 2567’s language that the “Administrator questioned the requirement of ensuring fire drills are held at unexpected times under varying conditions”. What was	08/21/2014

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	10:00 a.m., 09/30/13 at 2:00 p.m. and 08/28/13 at 1:00 p.m. Based on interview at the exit conference on 07/22/14 at 1:30 p.m., the Administrator questioned the requirement of documenting the transmission of the fire alarm signal to the monitoring station for the aforementioned fire drills. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure 12 of 12 fire drills were conducted under varied conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on review of Fire Drill Reports on 07/21/14 at 11:30 a.m. with the Maintenance Director, 9 of 12 fire drills conducted over the past four quarters were conducted near the end of the month: on 1/30/14, 2/28/14, 4/30/14, 5/30/14, 6/27/14, 12/30/13, 10/29/13, 9/30/13 and on 8/28/13. Based on interview at the exit conference on 07/22/14 at 1:30 p.m., the Administrator questioned the requirement of ensuring fire drills are held at unexpected times under varying conditions.		questioned was how our Fire Drill schedule did not meet the requirement that drills are held “at unexpected times”.	

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	3.1-19(b) 3.1-51(c)			
K020144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to exercise 2 of 2 generators for 12 of 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum	K020144	**K144** Facility will continue to inspect its generators weekly and exercise them under load for 30 minutes per month. **Corrective Actions:** Preventive Maintenance documentation on the generators has been revised so that there are two sets—one for each generator—instead of one set. Amperage has been added to the Generator PM checks. Load testing was completed and has been scheduled to be completed annually. Generators were tested and found to have transfer times of 9.5 and 9.7 seconds A second "letter of reliability" has been requested by the facility's natural gas supplier. **How Others Identified:** As noted in the 2567, this alleged deficient practice has the potential to affect all of the facility's residents. **Preventative Measures:** The Preventive Maintenance documentation, with respect to the generator, has been amended to include amperage and load. Annual load	08/21/2014

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	exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the emergency generator monthly test log maintained through electronic media with the Maintenance Director on 07/21/14 from 11:15 a.m. to 12:30 p.m., it could not be determined if the two generators met the requirements of Chapter 6-4.2 of NFPA 110 in that the only information documented was the start/end time, beginning engine oil pressure, ending engine oil pressure, ending water temperature and the battery voltage for each generator. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned issues regarding the generator. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds		testing has been arranged for in subsequent years. Load testing will include documentation of transfer times **Monitoring:** Generator Preventive Maintenance documentation will be forwarded to the facility's QAPI Committee for review for each of the next six months and annual thereafter. **Date of Completion: August 21, 2014**	

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	of building power loss for 12 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the emergency generator monthly test log maintained through electronic media with the Maintenance Director on 07/21/14 from 11:15 a.m. to 12:30 p.m., documentation of generator load transfer time for the past twelve months was not available for review. Based on interview at the time of record review, the Maintenance Director indicated no additional generator transfer time documentation was available for review and acknowledged generator load transfer time was not documented. 3.1-19(b)			

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	3. Based on interview, the facility failed to ensure the off-site fuel source for 2 of 2 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all residents, staff and visitors. Findings include: Based on interview with the Maintenance			

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	Director at 11:15 a.m. on 07/21/14, the fuel source for the two emergency generators is natural gas. Additionally, based on interview with the Maintenance Director, the facility did not have a letter from their natural gas provider indicating the natural gas was from a reliable source. 3.1-19(b)			